[*June* 15, 1946]

MEETING AT WINGFIELD MORRIS ORTHOPÆDIC HOSPITAL, OXFORD

The following *short papers*, illustrated by many cases, were read as follows:

Slipped Upper Femoral Epiphysis.—Mr. W. B. FOLEY.

Treatment of Acute Osteomyelitis with Penicillin.—Mrs. AGERHOLM (for Professor J. TRUETA).

Peripheral Nerve Grafting Operation.—Professor H. J. SEDDON.

Muscle Transplantation: Portion of the Pectoralis Major Muscle to Paralysed Biceps (With Film).—Professor H. J. SEDDON.

Organization of a Regional Accident Service.—Group Captain J. C. SCOTT.

Demonstration of a Self-Propelling Surgical Chair in its Early Stage of Construction.—Mr. GIRDLESTONE.

Tendon Transplantation for Radial Paralysis.—R. B. ZACHARY, F.R.C.S.

The classical method of tendon transplantation in radial paralysis is to transfer the pronator teres tendon into the extensors of the wrist, and to use flexor carpi ulnaris and flexor carpi radialis tendons for extension of the fingers and thumb. There is no argument about the value of using the pronator teres tendon for extension of the wrist, but the transplants to the fingers and thumb are not always satisfactory. We have found that if the palmaris longus is absent the transplantation of the tendons of both wrist flexor muscles leaves nothing to control the wrist, so that when an attempt is made to extend the fingers, the wrist goes into acute dorsiflexion and the fingers remain flexed at an angle of about 40 to 60 degrees. Moreover, this action of the wrist is the reverse of the normal process, for in the normal individual there is a tendency for the wrist to come to the neutral or slightly flexed position on opening the fist. It is clear that the fault is not a technical one such as slipping of the tendons, for if the wrist is passively held in the neutral position full extension of the fingers can be achieved.

When the palmaris longus muscle is present, the results are better but still uncertain. Some patients can control the wrist fairly well with the palmaris longus but others cannot, so that in this group of cases there are still a number in which the wrist-joint tends to dorsiflex when extending the fingers, with the result that the extension of the fingers is not complete.

In those cases where the flexor carpi radialis tendon has not been used, its control of the wrist allows full extension of the fingers and, moreover, strong active flexion of the wrist is maintained. It is, therefore, our policy in tendon transplantation for cases of radial paralysis to retain the flexor carpi radialis in its normal place and to use the palmaris longus as a transplant for the thumb if it is present. If the palmaris longus is absent, we have used the flexor carpi ulnaris for the thumb as well as for the fingers with success.

[*June* 19, 1946]

MEETING AT ROYAL SOCIETY OF MEDICINE, 1, WIMPOLE STREET, W

Dr. Sterling Bunnell (San Francisco) gave an Address entitled **Certain Aspects Of Hand Surgery In World War II.** This was summarized in the *Lancet*, 1946 (ii), 53.